

# **Exhibit 12**

**IN THE UNITED STATES DISTRICT COURT  
WESTERN DISTRICT OF VIRGINIA  
CHARLOTTESVILLE DIVISION**

Christopher Seaman, et al.,

Plaintiffs,

v.

The Commonwealth of Virginia, et al.,

Defendants.

Case No. 3:22-cv-00006-NKM

**Declaration of Fredric B. Garner, M.D.**

I, Dr. Fredric B. Garner, declare as follows under penalty of perjury pursuant to  
28 U.S.C. § 1746:

**Background**

1. I am over the age of 18 and a United States citizen. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and as an expert in pediatric medicine. If called as a witness, I could and would testify competently to the matters set for the below.

2. I have been a Board-certified practicing pediatrician for over 50 years. My clinical and research focuses include, among other things, serving as the principal investigator and sub investigator in more than 200 phase 2 and phase 3 pharmacologic FDA-approved clinical research studies, including HPV vaccine in adolescents and Moderna COVID vaccine in children 6 months to 12 years.

3. I earned my Doctorate of Medicine from the Medical College of Virginia in 1966. I then completed a pediatric residency at Children's Hospital Medical Center in Boston,

Massachusetts. Following my residency, I joined the U.S. Public Health Service wherein I earned the rank of Lieutenant Commander/Assistant Surgeon and served as the Chief of Pediatrics at the U.S. Public Health Service Hospital in Norfolk, Virginia.

4. During my career, I have taught at several medical schools including Harvard University Medical School, Pennsylvania State University Medical School, the University of Virginia Medical School, and Georgetown University Medical School. Most recently, I was an Affiliate Professor of Information Technology at George Mason University.

5. Additionally, I have, among other things, served as the Chairperson of the Pediatric Quality Improvement Committee at Fairfax Hospital for over a decade, served as Associate Chairperson for the Department of Pediatrics at the Group Health Association of Washington, D.C., served as the Chief of Pediatrics at Virginia Medical Associates, practicing as a primary care physician at Integrated Physician Services, and served as the Medical Director for Quality Improvement and Utilization Management at the George Washington University Health Plan.

6. I am currently a practicing pediatrician at Burke Pediatrics in Burke, Virginia and the Founder of Rx for Food, a first of its kind project to encourage office-based physicians to screen for food insecurity and provide direct access to food resources.

7. My *curriculum vitae* is attached as Exhibit A.

8. I am familiar with Governor Youngkin's Executive Order No. 2 prohibiting mask mandates in schools. In my expert opinion, this Order will hurt the children of the Commonwealth and their families by denying schools the ability to fashion policies for their districts that attend to the health needs of their students.

9. I am particularly concerned for those students with disabilities that increase the risk of severe illness should they contract COVID-19. If students face the prospect of going to school in areas of substantial or high risk of COVID-19 transmission, with no requirements for wearing masks, they are forced either to attend school at risk to their health and life and that of their families, or to stay out of school, risking their physical, psychological, emotional, and developmental well-being.

10. In addition, as we have seen with the Delta and Omicron variants, new variants of COVID-19 can be present in a community before they have been detected. COVID-19 variants in the future could pose greater risks to children and adolescents than the variants we have experienced thus far.

11. I am not being compensated for my time reviewing materials and preparing this declaration.

**I. Increased COVID-19 Transmission and Prevalence of the Omicron Variant in Virginia**

12. With the introduction of the highly-contagious Omicron Variant in the Fall of 2021, COVID-19 cases among Virginia's children have increased dramatically, to the highest levels since the pandemic began. The week of August 21, 2021, there were 4,468 COVID-19 cases among children in Virginia.<sup>1</sup> As of the week of January 15, 2022, that number had risen to

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<sup>1</sup> Virginia Department of Health>Coronavirus>See the Numbers> COVID-19 Data Insights> Cases Among Children, <https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-data-insights/cases-among-children/> (last visited Feb. 5, 2022).

24,959.<sup>2</sup> While the case numbers have decreased recently, they remain high, and the week of January 29, 2022, there were 9,177 cases among children in Virginia.<sup>3</sup>

13. As of January 29, 2022, the COVID-19 Omicron variant was estimated to account for over 99% of cases in the Department of Health and Human Services' Region 3, which encompasses Virginia.<sup>4</sup> This is relevant to the overall COVID-19 transmission landscape, given that the preliminary studies into the transmissibility of the Omicron variant suggest that it multiplies 70 times faster than the Delta variant in the upper respiratory tract.<sup>5</sup> This means that the Omicron variant spreads within communities at a much faster rate than previous variants.

14. I have also reviewed the county-level data regarding COVID-19 rates throughout Virginia that are referenced in the Complaint. This data demonstrates that Albemarle County, Manassas City, Henrico County, Chesterfield County, Cumberland County, York County, Bedford County, Chesapeake County, Loudoun County, and Fairfax County are experiencing a high rate of COVID-19 transmission right now.

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<sup>2</sup> Id. Virginia Department of Health>Coronavirus>See the Numbers> COVID-19 Data Insights> Cases Among Children, <https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-data-insights/cases-among-children/> (last visited Feb. 5, 2022).

<sup>3</sup> Id. Virginia Department of Health>Coronavirus>See the Numbers> COVID-19 Data Insights> Cases Among Children, <https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-data-insights/cases-among-children/> (last visited Feb. 5, 2022).

<sup>4</sup> CDC COVID Data Tracker: Variant Proportions, <https://covid.cdc.gov/covid-data-tracker/#variant-proportions> (last visited Feb. 5, 2022).

<sup>5</sup> “HKUMed finds Omicron SARS-CoV-2 can infect faster and better than Delta in human bronchus but with less severe infection in lung,” HKUMed News (Dec. 15, 2021), <https://www.med.hku.hk/en/news/press/20211215-omicron-sars-cov-2-infection> (last visited Feb. 6, 2022).

## **II. The Impact of the Omicron Variant for Children**

15. In my practice, which serves approximately 6,000 children and adolescents, primarily in Fairfax County, I have observed that children are becoming infected by the Omicron variant. The rate of COVID-19 infection among my patients mirrors the rate of COVID-19 infections among children across the nation, with the highest number of cases occurring in December 2021 and January 2022.

16. There is no doubt that children can and do get COVID. Additionally, when children contract COVID-19, it harms the entire family by disrupting their education, work, and socialization due to extended quarantines of siblings and parents living in the same household as the infected child.

17. Pediatric COVID-19 cases comprise an increasing share of overall COVID-19 cases, both in the United States and in Virginia. According to the most recent American Academy of Pediatrics *Children and Covid-19* report published on January 27, 2022, more than 3.5 million children nationally have been infected with COVID-19 since the beginning of 2022, which accounts for about 30% of all pediatric COVID-19 cases recorded since the beginning of the pandemic nearly two years ago.<sup>6</sup> Per the same report, as of January 27, 2022, the nationwide percentage of total COVID-19 cases involving children reached an all-time high of 18.6%, up from roughly 12% at this time in 2021.<sup>7</sup> In Virginia, the percentage of children represented in total COVID-19 cases was 19.3% as of January 27, 2022.<sup>8</sup>

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<sup>6</sup> Am. Acad. Pediatrics, Covid and Covid-19: State Data Report, (Jan. 27, 2022), <https://downloads.aap.org/AAP/PDF/AAP%20and%20CHA%20-%20Children%20and%20COVID-19%20State%20Data%20Report%201.27.22%20FINAL.pdf>; Figure 6. (last visited Feb. 7, 2022).

<sup>7</sup> *Id.* at Appendix Table 2A (last visited Feb. 7, 2022).

<sup>8</sup> *Id.* at Appendix Table 3B (last visited Feb. 7, 2022).

18. Since the beginning of the year, nearly 7,000 children nationwide have been hospitalized with COVID-19 compared to the first three weeks of 2021, when only about 1,000 children were hospitalized with COVID-19.<sup>9</sup> Children hospitalized with COVID-19 face the prospect of being admitted to the Intensive Care Unit, being put on a ventilator, and even death. The COVID-19 pandemic has resulted in the death of 910 children ages zero to eighteen in the United States as of February 2, 2022.<sup>10</sup>

19. While some studies suggest that the Omicron variant could lead to less severe illness on an individual basis, the increased contagiousness of this variant, both in lab studies and as reflected in COVID-19 case numbers across the United States, means that more total individuals could experience severe illness than with previous COVID-19 variants in Virginia and across the U.S.

20. Some children who have had COVID-19 will develop Multisystem Inflammatory Syndrome in Children (MIS-C), a serious condition associated with COVID-19. MIS-C is a condition where different body parts can become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs.<sup>11</sup> Symptoms of MIS-C include stomach pain, bloodshot eyes, diarrhea, lightheadedness, skin rashes, and vomiting.<sup>12</sup> In my own practice, we have treated a child who developed MIS-C as a result of contracting COVID-19. Children and

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<sup>9</sup> *Id.* at Appendix Table 2B (last visited Feb. 7, 2022).

<sup>10</sup> CDC, Deaths by Sex, Ages 0-18. <https://data.cdc.gov/NCHS/Deaths-by-Sex-Ages-0-18-years/xa4b-4pzy> (last visited Feb. 6, 2022).

<sup>11</sup> CDC, Multisystem Inflammatory Syndrome (MIS). <https://www.cdc.gov/mis/mis-c.html> (last visited Feb. 6, 2022).

<sup>12</sup> *Id.*

teens, ages 18 years and younger, who have had COVID-19 are up to 2.5 times more likely to be newly diagnosed with diabetes 30 days or more after infection.<sup>13</sup>

21. Children are also at risk of developing what has been come to be known as long COVID, where symptoms remain months after an initial COVID diagnosis, whether it was initially an acute or asymptomatic illness. While further study is essential to know the scope of long COVID in children, with current estimates varying significantly, medical researchers have raised concerns about the long-term impact of COVID on young people, even among the asymptomatic and those who were never tested but had the virus.

22. Although there are some treatment options for COVID caused by the Omicron variant in children, they are less effective than previously available treatments for Delta and original strains.

23. Finally, a new variant, BA.2 has been identified in the United States and its prevalence, contagion rate, and severity is unknown. More variants may come.

### **III. The Availability of Vaccines for Children and Overall Vaccination Rates in Virginia**

24. According to the CDC, unvaccinated people are much more likely to contract, transmit, and experience severe symptomatic illness from the Omicron variant than their vaccinated counterparts.<sup>14</sup>

25. Children in Virginia are the least vaccinated sub-population given the unavailability of the vaccine for children under the age of five. In Virginia, only about 30% of

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<sup>13</sup> Barrett CE, Koyama AK, Alvarez P, et al. Risk for Newly Diagnosed Diabetes >30 Days After SARS-CoV-2 Infection Among Persons Aged <18 years, United States, March 1, 2020-June 28, 2021. MMWR Morb Mortal Wkly Rep. ePub: 7 January 2022. DOI: <http://dx.doi.org/10.15585/mmwr.mm7102e2>.

<sup>14</sup> CDC Covid Data Tracker. <https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status> (last visited Feb. 6, 2022).



children between the ages of five and eleven are fully vaccinated<sup>15</sup> and, among children between the ages of five and seventeen, only 46.4% are fully vaccinated.<sup>16</sup>

26. The low rate of vaccination among Virginia's children leaves them more vulnerable to infection by COVID-19, and unvaccinated children who contract COVID-19 are more likely to contract the virus and to transmit the virus to their peers, especially in the absence of masks, social distancing, and other prevention measures.

27. In light of the data on pediatric vaccination rates and the unavailability of vaccines to the youngest school-aged children, children account for a disproportionate share of Americans to whom contracting the Omicron variant poses the greatest risk.

#### **IV. Conditions That Can Put Children at Greater Risk of Severe Illness from COVID-19**

28. Children with certain underlying medical conditions are at particularly increased risk of contracting COVID-19 and for developing a severe illness as a result of COVID-19 infection, even if they have been vaccinated. According to the CDC, "children with medical complexity, with genetic, neurological, metabolic conditions, or with congenital heart disease," as well as "children with obesity, diabetes, asthma or chronic lung disease, sickle cell disease, or immunosuppression" fall into this category.<sup>17</sup> I would also include children with cancer or children with cystic fibrosis.

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<sup>15</sup> U.S. Covid-19 vaccine tracker: See your state's progress, Mayo Clinic.  
<https://www.mayoclinic.org/coronavirus-covid-19/vaccine-tracker> (last visited Feb. 7, 2022).

<sup>16</sup> *COVID-19 in Virginia: Covid-19 Vaccine Demographics*, Va. Dep't of Health.  
<https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-in-virginia/covid-19-vaccine-summary/covid-19-vaccine-demographics/> (last visited Feb. 5, 2022).

<sup>17</sup> CDC People with Certain Medical Conditions (Update Dec. 14, 2021).  
<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html> (Last Visited Feb. 8, 2022)

29. Children with intellectual and/or developmental disabilities who are unable to maintain social distance, wear their mask properly, or adhere to recommended methods of mitigation are at increased risk of contracting COVID-19. These children need their community at large, including their school community, to employ best practices, including layered mitigation with universal masking, to protect them from contracting COVID-19.

30. Additionally, some children with underlying medical conditions cannot be vaccinated. These medically fragile, unvaccinated children are particularly vulnerable for contracting COVID-19 and suffering a severe COVID-19 infection.

31. Children who cannot be vaccinated because of their age or because of underlying medical conditions are at heightened risk of contracting, transmitting, and experiencing severe symptomatic illness from the Omicron variant. Many of the families I care for have expressed serious concerns about their children (those with complex health conditions and those without health issues) being in school and being exposed to COVID-19. No parent wants their child to get seriously ill or die. My practice includes children with disabilities including asthma, Cystic Fibrosis, cancer, organ transplants, and diabetes. I advise every parent, but especially those at high-risk of serious infection due to COVID-19, to vaccinate their children if they are eligible, to send their child to school wearing a N95 mask, if appropriate size given the age of the child, or other enhanced mask like a KN95. In fact, for much of the pandemic, my office would provide information on how to source hard-to-find N95 masks to our patients and other pediatric practices, and if families cannot procure an N95 mask, my practice would occasionally provide them to the family from our supply. My patients go to school in Fairfax County which has universal masking, but if my patient were going to school in a district without a mask mandate, I would advise them to request that their school require universal masking.

V. **CDC and State Department of Health Recommendations on Masking in Schools and the Efficacy of Masking for Reducing COVID-19 Transmission**

32. The CDC recommends “universal indoor masking by all students (ages 2 years and older), staff, teachers, and visitors to K-12 schools, regardless of vaccination status.”<sup>18</sup>

33. According to the CDC, “masks are primarily intended to reduce the emission of virus-laden droplets by the wearer (“source control”), which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others ... masks also help reduce inhalation of these droplets by the wearer (“filtration for wearer protection”). The community benefit of masking for SARS-CoV-2 control is due to the combination of these two effects (source control and filtration for wearer protection); individual prevention benefit increases with increasing numbers of people using masks consistently and correctly.”<sup>19</sup>

34. Leading medical organizations, including the American Academy of Pediatrics and the American Medical Association, similarly recommend universal masking as part of school openings.<sup>20</sup>

35. The Virginia Department of Health recognizes that “implementing prevention strategies to reduce risk associated with COVID-19 is a shared responsibility between parents

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<sup>18</sup> CDC Guidance for COVID-19 Prevention in K-12 Schools. <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-guidance.html> (last visited Feb. 6, 2022).

<sup>19</sup> Science Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2, CDC (December 6, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html> (citations omitted).

<sup>20</sup> [AMA welcomes Administration’s COVID-19 plan | American Medical Association \(ama-assn.org\)](#). (last visited Feb. 7, 2022) and [Face Masks \(aap.org\)](#). <https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/cloth-face-coverings/> (Last visited Feb. 7, 2022).

and families, school officials and staff, and local public health authorities.” The Virginia Department of Health also lists masks as one of the prevention strategies that parents should implement to reduce risk associated with COVID-19.<sup>21</sup> In fact, until the Order was signed, the Virginia Department of Health’s own “Mask Requirements and Recommendations,” provided that, in all indoor settings masks help protect against variants. The Department states that if an individual is up to date on COVID-19 vaccines, it recommends following CDC guidance to “wear a mask indoors when in areas with substantial to high transmission. If not up to date with COVID-19 vaccines, you should continue to wear a mask indoors and also while in outdoor crowded settings.”<sup>22</sup> Executive Order 2 contradicts all of this guidance and schools were suddenly excluded from the Department’s list of indoor settings when the Executive Order was signed.

36. The CDC determined, after a review of 15 studies including observational, epidemiological, and community-level analyses, that masks “not only effectively block most large droplets (i.e., 20-30 microns and larger), but they can also block the exhalation of fine droplets.” As a result, “[m]ulti-layer cloth masks can both block up to 50-70% of these fine droplets and particles,” with “[u]pwards of 80% blockage” recorded in some studies. To a

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<sup>21</sup> *Interim Guidance for COVID-19 Prevention in Virginia PreK-12 Schools*, Va. Dep’t. of Health and Va. Dep’t. of Education (Jan. 21, 2022), <https://www.vdh.virginia.gov/content/uploads/sites/182/2021/03/Interim-Guidance-to-K-12-School-Reopening.pdf>. (Last visited Feb. 7, 2022).

<sup>22</sup> *Protect Your Health Mask Requirements and Recommendations*, Va. Dep’t of Health <https://www.vdh.virginia.gov/coronavirus/protect-yourself/mask-requirements-and-recommendation/> (Last visited Feb. 7, 2022).

slightly lesser extent, masks also “help reduce inhalation of these droplets by the wearer”; multi-layer cloth masks can filter out “nearly 50% of fine particles less than 1 micron.”<sup>23</sup>

37. Additionally, recent studies have confirmed that wearing masks is one of the most effective tools to mitigate the transmission of COVID-1 in indoor settings, such as schools.

Specifically:

- a. A study examining SARS-CoV-2 secondary attack rates among eight public K-12 school districts in Massachusetts (70 schools with >33,000 enrolled students) during the 2020–21 school year found an unadjusted secondary attack rate of 11.7% for unmasked versus 1.7% for masked interactions;<sup>24</sup>
- b. Researchers at Duke University conducted a study on COVID-19 transmission within schools following “Plan A” which “provided full, in-person instruction, masking, and minimal physical distancing.” Using data from North Carolina K-12 schools—data that included more than 1,280,000 students and 160,000 staff—the Duke researchers found that “there is very limited within-school transmission of COVID-19 in schools participating in Plan A,” leading researchers to conclude that “wearing masks is an effective strategy to prevent in-school COVID-19 transmission;”<sup>25</sup>

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<sup>23</sup> Science Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2, CDC (December 6, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html> (citations omitted).

<sup>24</sup> Nelson SB, Dugdale CM, Bilinski A, Cosar D, Pollock NR, Ciaranello A. Prevalence and risk factors for in-school transmission of SARS-CoV-2 in Massachusetts K-12 public schools, 2020-2021. *medRxiv*. 2021; doi.org/10.1101/2021.09.22.21263900

<sup>25</sup> Letter from Danny Benjamin & Kanecia Zimmermen to Joint Legislative Education Oversight Committee et. al., (June 30, 2021). <https://absciencecollaborative.org/wp-content/uploads/2021/06/ABCs-Final-Report-June-2021.06-esig-DB-KZ-6-29-21.pdf>

- c. During the period of July 15 to August 31, 2021, about one in five K–12 public non-charter schools open for in-person learning in Maricopa and Pima Counties, Arizona, experienced a school-associated outbreak. Outbreaks were three and a half times more likely (adjusted odds ratio 3.5, 95% confidence interval 1.8-6.6) in schools without mask mandates;<sup>26</sup>
- d. In a nationwide analysis of data collected during the period of July 1 to September 4, 2021, U.S. counties without school mask requirements experienced larger increases in pediatric COVID-19 case rates (18.53 per 100,000 per day more cases) after the start of school compared with counties with school mask requirements;<sup>27</sup>
- e. A recent study in California using a test-negative case-control design, enrolling persons who received a positive (case-participants) or negative (control-participants) SARS-CoV-2 test result, from among all California residents, without age restriction, who received a molecular test result for SARS-CoV-2 during February 18–December 1, 2021 found that, in addition to being up-to-date with recommended COVID-19 vaccinations, consistently wearing a comfortable,

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<sup>26</sup> Jehn M, McCullough JM, Dale AP, Gue M, Eller B, Cullen T, Scott SE. Association between K–12 school mask policies and school-associated COVID-19 outbreaks — Maricopa and Pima Counties, Arizona, July–August 2021. *MMWR Morb Mortal Wkly Rep.* 2021; 70(39);1372–1373. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7039e1.htm> (Last visited Feb. 7, 2022).

<sup>27</sup> Budzyn SE, Panaggio MJ, Parks SE, Papazian M, Magid J, Eng M, Barrios LC. Pediatric COVID-19 cases in counties with and without school mask requirements — United States, July 1–September 4, 2021. *MMWR Morb Mortal Wkly Rep.* 2021; 70(39);1377–1378. <https://www.cdc.gov/mmwr/volumes/70/wr/mm7039e3.htm> (last visited Feb. 7, 2022)

well-fitting face mask or respirator (which offers the best protection) in indoor public settings protects against acquisition of SARS-CoV-2 infection; and<sup>28</sup>

- f. A study of California residents who tested positive between February 18 and December 1, 2021 found that consistent use of a face mask or respirator in indoor public settings was associated with lower odds of a positive SARS-CoV-2 test result. In other words, people who reported always wearing a mask in indoor public settings were less likely to test positive for COVID-19 than people who didn't.<sup>29</sup>

38. Numerous additional studies have found that increasing the rate of mask wearing, including through mask mandates, reduces community transmission significantly.<sup>30</sup> Studies have

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<sup>28</sup> Andrejka, KL, Pry, JM, Myers, JF, Fukui, N, DeGuzman, JL, Openshaw, J, Watt, JP, Lewnard, JA, Jaim, S, Effectiveness of Face Mask or Respirator Use in Indoor Public Settings for Prevention of SARS-CoV-2 Infection- California, February- December 2021. *MMWR Morb Mortal Wkly Rep. ePub.* 4 Feb. 2022.

<https://www.cdc.gov/mmwr/volumes/71/wr/mm7106e1.htm> (Last visited Feb. 7, 2022).

<sup>29</sup> *Id.*

<sup>30</sup> See, e.g., C.T. Leffler, et al., Association of Country-wide Coronavirus Mortality with Demographics, Testing, Lockdowns, and Public Wearing of Masks, 103 *Am. J. Tropical Med. Hyg.* 2400 (2020); X. Wang, et al., Association Between Universal Masking in a Health Care System and SARS-CoV-2 Positivity Among Health Care Workers, *JAMA* (July 14, 2020); T. Mitze, et al., Face Masks Considerably Reduce COVID-19 Cases in Germany: A Synthetic Control Method Approach (2020); M.E. Van Dyke, et al., Trends in County-Level COVID-19 Incidence in Counties With and Without a Mask Mandate – Kansas, June 1-August 23, 2020. 69 *Morbidity & Mortality Weekly Rep.* 1777 (2020); W. Lyu & G.L. Wehby, Community Use Of Face Masks And COVID-19: Evidence From A Natural Experiment Of State Mandates In The US, 39 *Health Aff.* 1419 (2020); H. Joo, et al., Decline in COVID-19 Hospitalization Growth Rates Associated with Statewide Mask Mandates — 10 States, March–October 2020. 70 *Morbidity & Mortality Weekly Rep.* 212 (Feb. 12, 2021); G.P. Guy, Jr., et al., Association of State-Issued Mask Mandates and Allowing On-Premises Restaurant Dining with County-Level COVID-19 Case and Death Growth Rates – United States, March 1-December 31, 2020. 70 *Morbidity & Mortal Weekly Rep.* 350 (2021).



shown in particular that masking and similar mitigation measures can limit transmission in schools.<sup>31</sup>

39. These studies confirm what the CDC has reported: available evidence continues to demonstrate that community use of well-fitting masks prevent COVID-19 transmission.<sup>32</sup> A literature review conducted in 2021 concluded that “nonmedical masks have been effective in reducing transmission of respiratory viruses; and places and time periods where mask usage is required or widespread have shown substantially lower community transmission.”<sup>33</sup>

## **VI. OPINIONS**

40. In my expert opinion, based on my review of the studies referenced above and on my medical knowledge as a physician, masking is an effective tool to prevent transmission of COVID-19, including of the Omicron variant.

41. Given the rise in pediatric infections (and adult infections) due to the Delta and Omicron variants (and the unknown risks of new variants like BA.2); the low vaccination rates amongst Virginia’s children; and the heightened risk of serious illness for children with disabilities or complex medical conditions, in my expert opinion the safest course at this time is

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<sup>31</sup> See, e.g., D.L. Gillespie, et al., The Experience of 2 Independent Schools With In-Person Learning During the COVID-19 Pandemic, 91 J. Sch. Health 347 (2021); R.B. Hershow, Low SARS-CoV-2 Transmission in Elementary Schools - Salt Lake County, Utah, December 3, 2020-January 31, 2021, 70 Morbidity & Mortality Weekly Rep. 442 (2021); A. Falk, et al., COVID-19 Cases and Transmission in 17 K-12 Schools - Wood County, Wisconsin, August 31-November 29, 2020, 70 Morbidity & Mortality Weekly Rep. 136 (2021).

<sup>32</sup> CDC, Scientific Brief: SARS-CoV-2 Transmission (May 7, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html> (last visited Feb. 5, 2022).

<sup>33</sup> Jeremy Howard, et. al., *An Evidence Review of Face Masks against COVID-19*, 188 Proc. Nat’l Acad. Science 1, 1-12 (2021). See also Yafang Cheng et. al., *Face Masks Effectively Limit the Probability of SARS-CoV-2 Transmission*, 372 Science 1439, 1439-1443 (2021).



universal masking at school and school-related functions. I also recommend that every person who is eligible for a vaccine get vaccinated.

42. In my expert opinion, community masking is a safe and effective tool. Masking is effective primarily as a source control, preventing or reducing the likelihood that the wearer will transmit the virus to individuals in his or her vicinity. Masks also operate to protect the mask-wearer from inhaling the virus to a lesser degree. Having only a portion of the population using masks does not provide the same level of protection as universal masking. In particular, because of the way this virus transmits, it is critical that not only the child with underlying conditions wear a mask but also those around that child.

43. Community masking is also critical for the health of those who, for reasons of disability, cannot mask whether because of motor skills or cognitive issues, people with sensory processing disorders, and people with facial deformities incompatible with a mask, among others.

44. COVID-19 can cause severe illness or death, especially among vulnerable populations, including children who are unvaccinated and children with complex medical histories. We also do not know the long-term impacts of a COVID-19 infection on the health of children. Severe illness and death are unacceptable for a preventable disease.

45. It is also my expert opinion that hospitalization for a child is not a benign experience. It is usually an anxiety-provoking and even traumatic experience which can lead to transient or long-term behavioral and psychological difficulties.

46. Virginia's Executive Order No. 2 denies school districts the ability to require masks when necessary to protect their students and staff. In communities where COVID-19 is prevalent, parents of children with conditions that can make them vulnerable to severe illness

face a terrible dilemma of whether to risk their children's health and even life, or to keep the children out of school. Death is an unacceptable risk and no parent should be forced to make this decision when we have the option of masks and other mitigation measures to help protect the safety of those in school.

47. In my opinion, school districts should have the right to implement masking as one of the tools we have to protect against increased transmission of this virus.

48. In my expert opinion, Executive Order No. 2 will hurt the children of the Commonwealth and their families by denying schools the ability to fashion policies for their districts that attend to the health needs of their students. If students with disabilities face the prospect of going to school in areas of substantial or high risk of COVID-19 transmission, with no requirements for wearing masks, they are forced either to attend school at increased risk to their health and life and that of their families or to stay out of school as a risk to their physical, psychological, emotional, and developmental well-being.

**I swear under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.**

Dated this 8<sup>th</sup> day of February 2022.

  
Fredric B. Garner, M.D.